

I-54 Develop interagency plans for prioritizing funding needs and technical assistance to meet tribal priorities such as:

- Public health planning
- Legal aid
- Media and information services
- Plans for dissemination of knowledge and sharing experience among local communities.

Strategy

Lead agencies: BLA, IHS, tribal governments

- *Timeframe:* Plans by December 1990

Implementation: ongoing as process evolves

Panel J

Treatment

Chair: Robert Niven, M.D.
Background Paper: Vernon Ellingstad, Ph.D.
Kathryn Stewart
Recorder: CAPT Frank Hamilton, M.D.
Panel Members: Loran Archer
Harvey Siegel, Ph.D.
Mark Goldman, Ph.D.
Chauncey Veatch III
James A. Farrow, M.D.
John Allen, Ph.D.
Jeri Shaw

Drinking and driving is a serious social and public health problem. Because of the enormous human and economic costs of drinking and driving on our society, the Panel on Treatment unanimously agrees that prevention and deterrence from drinking and driving are beneficial to all our society.

To improve traffic safety in the United States, the panel advocates the position that the safest blood alcohol level is 0.0 percent while driving and strongly recommends that the public service message should clearly state:

“If you are going to drive, don’t drink.”

The panel further advises that contrary or different messages, including “Know your limit” messages, should not be used.

From a public health perspective, all of the following recommendations are important. The panel opts to prioritize and rank order these recommendations according to which are most pressing and would enhance an effective response to this problem.

Prevention

Rehabilitative countermeasures, even if 100-percent successful, can have only a limited impact on traffic safety. The main approach to eliminating alcohol/drug-related injuries or fatalities must be focused on *prevention*.

J-1 Prevention measures, including both general and specific deterrence aimed at eliminating the behavior of driving while under the influence, are essential if major declines in mortality and morbidity are to be achieved. Prevention measures to be considered include traditional educational approaches and also public policy, enforcement, legal sanctions, and treatment measures. All messages, verbal and behavioral, should be clear, concise, noncontradictory, and focused on eliminating the joint activities of drinking and driving.

Strategy

The Surgeon General should immediately begin to promote a single public health message concerning drinking. This message should be "Don't drink and drive." Any contrary messages to this should be discouraged, including "Know your limits" messages.

The Surgeon General should ensure that all Federal Government promotional materials about drinking and driving be revised to reflect this position by the National Drunk and Drugged Driving Awareness Week in 1989 and should ask all voluntary agencies concerned with drunk driving to adopt an identical message and to discourage contrary messages.

The Surgeon General should convene a multidisciplinary task force to develop mechanisms to coordinate and increase prevention efforts and the recommendations from this and other task forces involved in the Surgeon General's Workshop on Drunk Driving.

The Surgeon General, acting through the Public Health Service, should create a variety of educational materials on drunk driving which should be widely distributed (including through chemical dependency and other health care facilities and organizations) and incorporated in health care training didactic and clinical curriculums. The creation and dissemination of these materials should be completed by the National Drunk and Drugged Driving Awareness Week in 1989, or as soon as possible.

Treatment

J-2 Treatment should not routinely be used as a *substitute* for legal sanctions, but rather as an important component of a comprehensive traffic safety program.

Driving under the influence of alcohol or other drugs is a multifaceted problem for which there is no *single* effective treatment of any type (medical, legal, or punitive).

Treatment programs reduce driving related alcohol/drug incidents in those alcohol/drug dependent persons successfully treated, both those with and those without prior DUI offenses. Such programs are also a resource (as are other components of the health care delivery system) to further the dissemination of prevention materials.

A systematic approach to offenders using qualified personnel, appropriate standards, with oversight and quality assurance controls and without conflict of interest, is necessary to assess those persons who may benefit from one or a combination of treatment approaches. Such a systematic approach also needs ongoing evaluation to develop answers to relevant questions and enhance cost-effectiveness.

The traditional short-term, low-intensity educational programs that are broadly applied have been of limited effectiveness, and more intensive, longer term treatment options may be more beneficial (albeit more costly) and perhaps applicable to a selected population of offenders.

Strategy

Since a significant body of research supports the role of legal sanctions, in particular licensing sanctions, in reducing DUI recidivism, the Surgeon General should encourage Federal, State, and local governments to adopt and promulgate policies and practices that offer treatment in combination with licensing penalties and other sanctions proven to be effective and to discourage offering treatment in lieu of other known, effective sanctions.

Because of the wide variations in the structure and quality of assessment and treatment programs from State to State, the Surgeon General should promote and encourage States to develop mechanisms for high-quality diagnostic and referral procedures for DUI offenders and, specifically, should encourage the use of uniform diagnostic criteria and assessment instruments and treatment approaches, since this would greatly facilitate research studies on the effectiveness and cost-effectiveness of treatment.

Research

J-3 Develop a precise data base on the incidence and prevalence of driving under the influence in different population groups. Since drunk drivers comprise a heterogeneous population, specific demographic identifiers among this population need to be defined. Special populations (i.e., youth, minorities, and women) should be targeted in obtaining these data.

J-4 Intensively investigate the neuroscientific basis of high-risk, impulsive behavior and recidivism in this population.

J-5 Develop a scientific evaluation of treatment modalities and the combination of various treatment options for the heterogeneous group that makes up the drunk-driving population.

J-6 Evaluate the effectiveness of new, short-term low-intensity programs that have an impact on behavior from both an outcome and a process perspective.

J-7 Develop and evaluate newer treatment modalities in high-risk populations.

Strategy

The Surgeon General should encourage and foster research and the coordination of research activities of various U.S. Government Agencies involved in this field, to increase the quantity and quality of research focused on the drunk driving issues identified by the task force. A priority in this area, which requires an immediate increase in research, is the assessment of subpopulations who are already underrepresented in existing knowledge bases.

The Surgeon General should encourage States and local government agencies to develop uniform data collection, assessment, and treatment methodologies, since such information would provide an invaluable basis for the further development of public policy initiatives aimed at minimizing the enormous adverse impact of drunk driving.

Resources

Significant increases in fiscal and personnel resources will be required for success, but this is not seen as the sole responsibility of the Federal or State Governments.

J-8 Since DUI has significant economic impact, funds should be used judiciously at all levels of State, local, and Federal Government. In allocating resources to address this issue of traffic safety, funds earmarked for public education should be given the highest priority. Evaluation and reevaluation of current treatment programs that are most cost effective and provide the most efficient treatment are encouraged.

J-9 Coordination and leadership, at the highest levels of government and in the private sector, are also necessary if impaired driving is to be eliminated. Involvement of health, judicial, law enforcement, transportation, and education departments, in an intense and truly cooperative effort, will facilitate the involvement of universities, business, and private groups in developing, implementing, and testing strategies to eliminate this national tragedy.

J-10 The cost of treatment should be borne as much as possible by individuals convicted of DUI, based on their ability to pay. If the individual is unable to pay, the individual's high-risk group (those convicted of DUI) should bear the cost.

Resources for supporting this prevention and rehabilitative endeavor would be derived from revenue from fees, penalties, and other appropriate sources.

Strategy

In view of scientific data indicating the limited effectiveness of short-term, low-intensity educational programs, which are the most common approach to DUI offenders, the Surgeon General should encourage States and local governments to reassess the use of resources currently devoted to such programs and to consider retargeting resources to other treatment or prevention strategies.

Panel K

Citizen Advocacy

Chair: Howard Filston, M.D.
Background Paper: John McCarthy, Ph.D.
Recorder: CAPT Patricia D. Mail
Panel Members: Mickey Sadoff
Rebecca Brown
Ann Esch
Nancy Ricci
Ritchie Aanderud
Marsha Woodward
Harold Brandt, M.D.
Wes Roy
Sue Rusche

Citizen advocacy represents a broad focus of concern that cuts across the more specifically defined issues associated with driving while intoxicated (DWI). Having its roots in the towns and communities of the Nation where the problem of DWI is most omnipresent, the citizen advocate's concerns encompass all aspects of DWI from advertising and marketing through enforcement, judicial and administrative issues, and treatment. But the greatest concentration of effort is in education, for it is through education of the judiciary, legislature, and citizenry that the dramatic efforts to reduce and eliminate DWI are concentrated. Only continued community awareness can bring about the type of behavioral and attitudinal changes necessary to ensure the safety of the Nation's highways from impaired operators of motor vehicles.

The Citizen Advocacy Panel was charged with addressing a range of issues, many of which are being addressed by other panels in the workshop. After wrestling with these charges, it became apparent that continued deliberations would only serve to duplicate the recommendations of the other panels. Each of the charges represented a vital and important issue,

and there was insufficient time to address each in the detail required. The panel members are concerned that citizen advocates were not empaneled as members of each of the other panels, for only in that fashion could the citizen advocates voice their unique concerns.

The citizen advocate is able to represent the perspectives and issues that cut across jurisdictional lines; represent victim viewpoints; challenge inaccuracies and inconsistencies in the law, its enforcement, and disposition; and speak out as a conscience for necessary action.

The panel proceeded to address several issues that were of particular and continued concern to advocacy groups. The panel also went on record as supporting and endorsing the recommendations of the *Presidential Commission on Drunk Driving* (1983) and the *Youth Driving Without Impairment Report of the National Commission Against Drunk Driving* (1988). In addition, the panel addressed the special roles and responsibilities of citizen advocates and supported the mandate provided by their inclusion in this workshop that citizen advocacy groups continue to give the issue of DWI the full force of concern in our society which this grave problem deserves.

The panel makes the following recommendations to the Surgeon General.

Recommendations for Advocacy Groups

K-1 Develop a coalition of national and local advocacy groups for the purpose of coordination, exchange of information, and strategic planning.

Strategy

An agency should be identified, such as the National Highway Traffic Safety Administration (NHTSA), under whose sponsorship a meeting of advocacy groups could be convened to initiate coalition building. This conference could occur in conjunction with the next Lifesavers Conference, April 1989.

The NHTSA grant programs should provide funding for regional workshops on drinking and driving to facilitate coalition building on a regional basis. Because of the already established networks of NHTSA, the Surgeon General should encourage the Congress to increase appropriations for NHTSA's grant programs. If coordination with Lifesavers is not feasible, then other sources of support for a coalition-building conference should be sought and a preliminary meeting held during 1989.

K-2 Establish a national clearinghouse of information about impaired driving issues and advocacy activities as a resource for advocates and the general public.

Strategy

The Surgeon General should provide the leadership to coordinate appropriate agencies to identify funding and establish a National Impaired Driving Prevention Information Clearinghouse to help advocacy groups and other interested parties.

- *This should be initiated by the end of fiscal year 1989.*

K-3 Advocacy groups should educate themselves with regard to all aspects and issues of impaired driving to ensure that they have the most accurate and up-to-date knowledge about the problems.

Strategy

The National Impaired Driving Prevention Information Clearinghouse would serve as a major source of information and training materials for advocacy groups and individuals interested in becoming advocates. Advocates who interact with the press or the legislators must know current laws and legislative initiatives for improving them.

K-4 Of all the activities in which advocates are involved, the major efforts should be directed toward four primary activities that are not emphasized by any other group:

- Court monitoring
- Victim assistance
- Influencing public policy and legislation
- Ongoing awareness and public education

Strategy

The National Clearinghouse would be a resource for information to support these activities, provide training material, serve as a repository for model legislation, and provide assistance with the development of appropriate materials. However, nothing will be accomplished without energetic and vigilant efforts by local advocates.

K-5 Advocacy groups should continue to expand their volunteer base, drawing on both victims and potential victims.

K-6 It is important for advocacy groups to keep their volunteers happy and productive. Volunteers require training in order to be well prepared and comfortable with their tasks. A variety of activities should exist that challenge and utilize the broad range of volunteer skills and talents that the individual members bring with their commitment.

Strategy

Advocate participants need to take back to their organizations the recommendations presented at the workshop and to seek ways to both implement and encourage support for the recommendations, giving them wide publicity and assuring the widest possible distribution of the subsequent report.

The Proceedings of the Surgeon General's Workshop on Drunk Driving should be sent to all of the following:

- State governors*
- State legislators*
- State Attorneys General*
- Members of the U.S. Congress*
- National advocacy groups*
- Federal Judges and members of the U.S. Supreme Court*
- Members of the Presidential Commission on Drunk Driving*
- Advocacy group officers*
- Members of the citizen advocacy panel.*

In addition, copies should be made available to the National Clearinghouse for Alcohol and Drug Information for distribution to advocacy group chapters nationally through NCADI's Regional Alcohol and Drug Awareness Resource (RADAR) Network and the National Institute of Justice Clearinghouse.

Copies should also be sent to the national officers and all State presidents of the League of Women Voters.

K-7 Advocacy groups must continually seek a variety of resources within their communities to support their activities, including help from corporations, foundations, individuals, and governmental entities.

K-8 Advocates should seek opportunities to recognize and reward those individuals whose behavior and actions are necessary and appropriate to the task of removing impaired drivers from the streets and streams of America. Appropriate behavior should be reinforced and recognized, whether through the services of volunteers or from administrators, law enforcement officers, judges, probation officers, legislators, or other professionals.

Strategy

When a national clearinghouse is established, one service might be the development and dissemination of a newsletter that would feature volunteers and professionals and recognize their important contributions to getting impaired drivers off the Nation's highways.

K-9 Advocates must be on the alert to identify the unaddressed potential situations in their communities that create a climate for excessive alcohol consumption. Excessive drinking at sporting events or festivals should be discouraged. Those individuals responsible for the planning of public events should be encouraged to seek ways to reduce and control the ready availability of alcohol and to actively discourage DWI while promoting alternatives.

Strategy

This activity is a major responsibility of local advocacy groups. Distribution of the workshop proceedings will help to disseminate this information.

K-10 Advocates must be constantly on the alert for attempts within their community or State to revoke and/or weaken established laws and policies by appending revocation language onto otherwise unrelated bills.

Strategy

A clearinghouse would help make such attempts widely known, and the tactics in one State would be exposed for all to learn from and guard against in their own States.

Additional Recommendations

In addition to recommendations specific to citizen advocates, the panel also wishes to go on record regarding issues that are of great concern to citizen advocates.

K-11 Emphasize that DWI is a national catastrophe (crisis) representing a most serious threat to the public health and deserving of extensive and continuous attention at all levels of government and society.

K-12 State clearly that Driving Under the Influence (DUI) or Driving While Intoxicated (DWI) is a crime and deserving of criminal sanctions, even for the first offense. Use a twofold attack consisting of administrative license revocation per se combined with criminal sanctions. Although some leniency in punishment and emphasis on education toward behavior modification are appropriate for first offenders not involved in crashes resulting in injury or death, the importance of establishing a record of this first offense as a *crime* cannot be overstated, for it then becomes the basis for more punitive sanctions for the multiple offender.

Strategy

This needs to be stated and restated, not only by the Surgeon General, but by the U.S. Attorney General and Federal and State attorneys.

To help publicize the magnitude of this issue and to give prominence to the pervasiveness of DWI in the country, reports of DWI and related criminal activities, such as hit-and-run, should be regularly incorporated in the FBI's Uniform Crime Report.

- *Incorporation of such reporting to be initiated by October 1989.*

K-13 Increase national attention on DWI and the events leading up to this act. To accomplish this, use of properly descriptive language must be strongly encouraged. This includes the fact that alcohol-related crashes and injuries are not "accidents."

Strategy

The Surgeon General should encourage all major medical organizations and the Centers for Disease Control to define alcohol-related episodes as crashes, with resultant injuries where appropriate, and to cease using the word "accident." The CDC should commence regularly reporting alcohol-related crash injuries and deaths. These deaths and injuries due to DWI should be regularly tracked and reported in the Center for Disease Control's Morbidity and Mortality Weekly Report. The latter will help to raise health professional awareness about the magnitude of the problem.

- *This should be initiated by October 1, 1989.*

K-14 Increase the use of sobriety checkpoints on the Nation's roads and highways and reinstate them in those States that have declared them unconstitutional.

Strategy

The U.S. Attorney General should promulgate the model standards for setting up such checkpoints. A summary of the issues relating to this recommendation may be found in the Impaired Driving Issues Compendium (1989), prepared by Mothers Against Drunk Driving:

The National Association of Chiefs of Police, other law enforcement associations, the Justice Department, and NHTSA should all strongly urge the use of checkpoints. NHTSA should encourage State Attorneys General to review their local laws and make changes as needed to implement checkpoints, as well as to provide guidelines to their members and the various states on the legal implementation of such checkpoints.

Advocates need to inform themselves about this issue and determine what their local and State policies are regarding checkpoints. With volunteer legal consultation, conduct a review of local laws to determine where modification may be needed to implement or reinstitute checkpoints.

- *All of the above with preliminary implementation by December 31, 1990.*

K-15 Significantly lower the per se BAC of 0.10 and apply this lowered standard to the general public consistently throughout the United States. Standards should be consistent with either the recommendations of the American Medical Association (.05) or those currently being applied to commercial transportation operators (.04). The permissible BAC for drivers under the age of 21 should be established at 0.00 nationally.

Strategy

The U.S. Public Health Service should charge its appropriate Agencies to begin a review of all relevant research immediately to determine appropriate BAC levels to safely operate motor vehicles, and issue a report on their findings not later than December 30, 1990.

When this determination is made, the information should be forwarded to NHTSA and the Departments of Justice, Education, and Defense for the widest possible promulgation. In addition, the PHS should forward a recommendation to the appropriate

Congressional Committees to consider development of legislation to establish this level nationally.

Advocacy groups should urge the adoption of the level on a State-by-State basis.

If all legislative avenues to establish a physiologically relevant standard fail, then the Congress should consider withholding Federal highway trust funds from States, as part of a total package of mandating model standards for the public health and safety.

- *Effective legislation and enforcement could be in place by 1992. The PHS can probably conduct a review of research and make a recommendation by the end of FY 1990.*

K-16 Adopt uniform graduated penalties for DWI in the States and territories, with special focus on multiple offenders, especially those individuals driving with revoked licenses.

Strategy

The Surgeon General should ask NHTSA to work with advocacy groups, law enforcement officials, and appropriate judiciary organizations to develop such models and supportive educational material.

The resources of NHTSA should be directed to convening an expert working group to establish standard graduated sanctions, with particular emphasis on multiple offenses, driving under license revocation, and penalties for those who knowingly lend a vehicle to an individual who has a revoked license.

K-17 Establish a national computer registry of DWI offenders in which the recognition of DWI in any State has reciprocity and recognition in all other States. This should be available to licensing bureaus and all enforcement officers through a network like the Federal Bureau of Investigation's National Crime Information Center (NCIC).

Strategy

The Congress is urged to appropriate funds to implement the 1988 Drunk Driving Prevention Act, and advocacy groups nationally should also urge passage of the provisions of this law in their individual States.

In addition, the Surgeon General should request participation of the

Justice Department and other appropriate law enforcement agencies and institutions to review and recommend the most expedient manner for creation of this data base.

- *Review and recommendations regarding feasibility and cost could be completed by the end of FY 1990 and the Registry be implemented by the end of FY 1992.*

K-18 All States should incorporate into their driver qualification tests questions on the effects of drinking and driving and the penalties for violations.

Strategy

Advocacy groups should urge incorporation through their legislators and licensing bodies.

- *To begin immediately.*

K-19 Testing for BAC should be mandatory as evidence in any crash, injury, or death in which a motorized vehicle is involved (including boats, snowmobiles, and other all-terrain and off-road vehicles).

Strategy

The U.S. Attorney General should restate the requirements of the Uniform Vehicle Code as they pertain to mandatory testing, and testing should be applied in all traffic crashes resulting in fatalities or bodily injury.

- *This emphasis needs to be promulgated immediately and consistently, certainly as soon as possible after the new Attorney General takes office January 20, 1989.*

K-20 Require all medical personnel in trauma centers and emergency rooms to conduct BAC testing and report suspected DWI offenders to the proper authorities. These laws would be similar to the child abuse laws in which clinicians are protected against prosecution for compliance, but compliance is mandatory.

Strategy

The U.S. Attorney General should recommend legislation to provide protection from prosecution of medical personnel and request that this requirement be inserted into appropriate legislation.

Advocates should work with their local medical societies, State medical associations, and the Attorney General to draft legislation to implement and enforce this reporting.

- *Mandatory reporting to be passed by at least five States by December 1992.*

K-21 Establish programs of victim assistance for the injured as well as the dead. These programs should provide help not only with court proceedings, but with compensation and treatment, both physical and psychological.

Strategy

Advocacy groups, working with the Department of Justice and NHTSA, should establish a Victims Bill of Rights, to be incorporated into newly drafted highway safety legislation that is designed to fill the gaps in the current drunk driving legislation.

The Department of Justice should promote the Victims Bill of Rights, including the admissibility of Victim Impact Statements for adoption into law.

- *By December 1, 1990.*

A model law needs to be developed to address the issue of nonfatal injuries incurred in an alcohol-related crash. This must include restitution/compensation for any degree of injury that occurs. This model law needs to be incorporated as a statute in new legislation. Such legislation should be developed during a consensus conference sponsored by NHTSA.

- *By December 31, 1991.*

K-22 The Department of Justice and other interested parties should file amicus briefs before the next session (and, if necessary, in any future sessions) of the Supreme Court (e.g., *South Carolina vs. Gathers* 88-305 or others) in an effort to reverse the high court's decision on *Booth vs. Maryland* (107 S.Ct. 2529 [1987]) regarding the admissibility of Victim Impact Statements.

Strategy

The U.S. Attorney General should submit an amicus brief to the court in support of the admissibility of Victim Impact Statements.

- *By April 1, 1989.*

K-23 Focus increased attention on the issue of alcoholic or codependent denial and its insidious influence on those who are charged with the public responsibility of addressing and dealing effectively with impaired driver issues at all levels. This includes impaired or addicted individuals in education, the criminal justice system, the medical care system, and private citizens whose own illness may negatively impact their ability to behave in an appropriate and lawful manner.

Strategy

The U.S. Public Health Service, through appropriate agencies, should facilitate increased awareness of addiction and the attributes of an impaired individual, with strong encouragement for the increased availability of employee assistance programs and other detection and treatment measures. This education should be conducted cooperatively with NHTSA and the Departments of Defense and Education.

- *Preliminary information on denial and codependency should be provided to professional preparation institutions, both law and medicine, by December 31, 1989.*
- *Supervisors in all major Federal Agencies should receive information on impairment and the availability of employee assistance programs in their Agencies by October 1, 1990.*

The PHS, through the educational resources of the CDC, should develop counteradvertising messages for youth to illustrate the negative consequences of alcohol abuse and to foster a climate of nonalcoholic sociability.

- *Public service announcements should be pilot tested and available by June 30, 1990.*

The panel reiterates that the most important single element in addressing all the issues of drunk driving is *education*. Continual community awareness about the severity and seriousness of DWI must be the responsibility of all individuals who wish to protect themselves, their property, and their lives from serious injury or death.

The members of the Citizen Advocacy Panel wish to thank Surgeon General C. Everett Koop for his concern and his willingness to put the full weight of his office and the attention of the U.S. Public Health Service on the issue of drunk driving.

NOTE: The Citizen Advocacy Panel recommends to all concerned readers the MADD *Impaired Drivers Issues Compendium*, which provides detailed information about many of the issues discussed at the workshop.

Closing Remarks

C. Everett Koop, M.D., Sc.D.

Surgeon General of the U.S. Public Health Service

U.S. Department of Health and Human Services

I'm certain there are no reasonable people who believe that drunk driving should be tolerated. Yet people shy away from any discussion deeper than "isn't it terrible." Leadership is hard to come by, because it is a lonely position. Although this workshop had the enthusiastic representation of five cabinet departments in planning, only one cabinet secretary — Dr. Otis Bowen — appeared at this meeting.

It is never an easy assignment to respond to workshop recommendations because the time is short, the number of recommendations great, and the Surgeon General has neither budget nor power, save the power of moral suasion.

It has been my custom to keep the participants and other interested individuals and organizations apprised of initiatives undertaken and other activities 6 months and 1 year after publication of the booklet. On selected subjects in former workshops, annual progress reports have also been provided to participants.

I am pleased that Jeffrey Miller and Loran Archer have been able to respond to your deliberations and, believe me, I am grateful to them. They have indicated a willingness to work with us, and you have heard what a resource they are for you.

I find myself in the cleanup position, and since the other respondents and I have already conferred, I will try not to be repetitious. Since the subjects of many of the panels are crosscutting, generic remarks covering all panels seem appropriate. Obviously, I will properly refer recommendations with a narrow focus to appropriate agencies. And when recommendations are sent, *all* will be sent because of the overlaps and crosscutting of some issues and panels.

The advertising and marketing recommendations remind me of the first, and at times faltering, steps taken 25 years ago in reference to tobacco advertising. I'm not being critical; that's a compliment.

In reference to the research recommendations, you have already heard from Mr. Archer. I will discuss them with Mr. Archer and Dr. Gordis of NIAAA, and with Dr. Fred Goodwin, Administrator of ADAMHA, as well as getting them exposure in appropriate media catering to the academic community.

I will present the epidemiology panel's recommendations to Dr. James Mason, Director of the Centers for Disease Control (CDC), for a critique for feasibility on the part of the Federal Government and request that he report on current and future plans of the CDC that may address specific recommendations. I will also ask for the cooperation of the CDC in wide dissemination of the panel's findings.

Education is probably where I can be most effective, and I pledge myself to this effort both now as your Surgeon General and later when I leave this office for the private sector.

I will seek appropriate counsel regarding the broad dissemination of the judicial and administrative enforcement recommendations to those agencies most likely to have responsibility and/or the ability to act.

I will undertake to deliver to organized medicine by appropriate means – personal and by transmittal – concerns and recommendations of the injury control and treatment panels. I will be contacting these organizations early on:

- American Medical Association – especially the student sector
- National Medical Association – for some of the ethnic considerations
- American Academy of Pediatrics
- American College of Surgeons
- American College of Preventive Medicine
- American Academy of Family Physicians
- American Trauma Society and others that will come to mind or be suggested by you.

Appropriate contact will also be made with the following groups to expedite the recommendations on youth and other special populations.

- National PTA
- National School Board Association
- The various associations of school principals
- The National Education Association.

My work with these groups over the past few years regarding AIDS gives me easy access and ready credibility.

But also: Boy Scouts, Girl Scouts, Camp Fire Girls, 4-H Clubs, and others.

I note the crosscutting nature of the concerns of the citizen advocacy panel. I will convene a group (and welcome suggestions from the panel) to consider the formation of a nonprofit corporation of the 501(c)3 type to act as an umbrella for a coalition to be supported by dues – to set its own agenda. I will provide funds to pay legal fees and other expenses to get this off the ground.

I will seek to put this new organization in touch with possible ongoing sources of funding. Believe me, this is an effective and productive tool, judging from our post-workshop experiences with organ procurement for transplants, child abuse, resource location for handicapped children, self-help, and so on. I will see that these recommendations reach the widest possible audience, because we *all* must be advocates.

And now for some comments that apply to all panels – I will:

- Use my relationship with organized medicine to give the final product of this workshop the broadest applications.
- See that a copy of the final document goes to each Senator and each Congressman with an appropriate covering letter from me.
- Do the same for the chiefs of staff of the various congressional committees that could have a legislative interest in these recommendations.
- Present these findings in detail and with additional comments to the Association of State and Territorial Health Officers at their annual meeting in the spring.
- Seek an appropriate opportunity to address municipal and county health officers in the same manner.
- Personally sit down with the new Secretary of the Department of Health and Human Services soon and with the new Surgeon General eventually and solicit their personal involvement because of the gravity of the situation and the need for action, and
- Wherever possible, I will lay the burden on government agencies, private agencies, and academia and seek cooperation at every level.

When the new administration is underway, I will see that the governors of each State and territory receive the complete set of documents with a covering letter from me.

Now for a final word. Strange as it may seem, there are a few people and organizations who would have preferred that we *not* meet on this subject this week — or maybe ever.

I guess by now everyone knows of my correspondence with Mr. Edward O. Fritts, President of the National Association of Broadcasters (NAB) inasmuch as the press had his letter to me when I received my copy. His is a key organization, I won't deny that. I wanted him and the NAB to be here with us. I wanted everyone to hear the NAB's point of view not only because broadcasters are very influential — as we all know — but because they also have so much at stake in this issue. Hence, they certainly have a right to be here.

That's why I invited Mr. Edward Fritts. And that's why I also invited Mr. John O'Toole, the Executive Vice-President of the American Association of Advertising Agencies (the "4-A's"), and Mr. Dewitt Helm, the President of the Association of National Advertisers, the people who are the *clients* of the 4-A's.

But all three declined. Mr. O'Toole and Mr. Helm suggested that our workshop lacked "good balance." They also said they had very little time to prepare for the discussion that would no doubt take place here. And each person suggested I cancel the workshop.

I was sorry to get their replies. But, if I may say so, I think their complaints and suggestions are quite unfair. Now, it is true that one message that might be heard at this workshop is this one: *alcohol contributes to injury and premature death.*

That's a troubling message, to be sure, and one's instincts might well be, figuratively speaking, to "kill the messenger" — in this case, discredit this workshop or have it cancelled. If so, then Mr. O'Toole's and Mr. Helm's strategy didn't work.

However, the letter to me from Mr. Fritts of the NAB was a bit more unsettling because it contained this observation:

At best, this workshop is designed to politicize the emotional tragedy of drunk driving. At worst, it is a total abuse of the policy-setting process.

In addition to being surprised at that *unfortunate* choice of words, I was taken aback by that observation, since over the past 7 years I have personally convened and conducted a dozen workshops, several at the request of President Reagan, dealing with such difficult issues as —

- Organ transplantation;
- Domestic violence;
- The needs of handicapped children and their families; and

- The role of the self-help movement in public health.

And I've conducted workshops on child pornography and public health and on the care of children who are born with AIDS, and so on. *None* of these workshops was called to "politicize an emotional tragedy," and *all* these workshops contributed significantly to the policymaking process of this administration. As will *this* one, I am sure.

I don't wish to dwell on the NAB's criticism because it may be nothing more than an early and predictable phase in the industry's learning process.

That's been the immediate response from the broadcasting and the advertising industries. We obviously must wait for them to offer something more helpful. But what are the chances that will happen? If history is any guide, the chances might be slim.

I hope that's not the case, because the history of smoking and health is not encouraging. I've reviewed the way the tobacco, broadcasting, and advertising industries behaved around the time my predecessor, the late Dr. Luther Terry, released the first *Smoking and Health Report* 25 years ago. From that review I can see that, even at this early stage of discussion, there are already similarities of behavior.

And that's a shame. I think we'd all prefer that these industries — and their chosen leaders — would heed the oft-quoted wisdom of George Santayana, who wrote

Those who cannot remember the past are condemned to repeat it.

I can tell you that I, for one, would rather *not* repeat the difficult times we had in the past. I do not think the confrontations were always necessary or fruitful.

But some aspects of the past *are* worth noting and worth emulating. For example, 25 years ago the public health community, with the support of many citizens' groups and a substantial number of members of Congress, embarked upon a systematic program of research into the relationship between smoking and health.

At the same time, and in a responsible way, we also began to look at the public policy implications of the research results, as they came to light. From that information we were able to plan ways to help the American people cast off this high-risk health behavior: smoking. And that meant principally a long-range and unremitting program of public education and instruction. That's what happened regarding the issue of smoking and health. And certainly drinking and driving is high-risk behavior amenable to education and instruction.

I respectfully suggest that Mr. Fritts, Mr. O'Toole, and Mr. Helm — and

their colleagues – review that history as I did, because the American people may now be – in terms of alcohol – where we were 25 years ago in terms of tobacco.

The relationship of the National Commission Against Drunk Driving and this workshop provides a puzzle not easy to solve. That we – the Commission and this workshop – have the same presumed goal should be obvious. That we should stand together makes sense.

Yet Mr. Adduci, Chairman of the Commission, cleverly suggested to me in a letter of November 28, 1988, that “you may be considering the following along with other options.” One option was to “disregard the views and position of the National Association of Broadcasters.” Another was to postpone this meeting, and a third was to “notify all panelists that (my) office had overlooked or was unaware of the fact that DOT had given the National Commission a \$100,000 grant to do a 16-month assessment of its initiatives.”

After further correspondence with me and conversations with my staff, it was agreed that Mr. Adduci and I would let no light be seen between us as we stood side by side in this effort to reduce the carnage on our highways and streets. And that either Mr. Adduci or his program director, Dr. Grant, would speak at the opening plenary session.

This seemed very appropriate in view of the published report of the commission on “youth driving without impairment,” excerpts of which both Dr. Bowen and I read the day before yesterday at the plenary and commented upon favorably.

Yet when the confirmatory letter was faxed to me on the 13th – the day before this workshop opened – there was a quid pro quo. In return for that speech, we would not release conclusions or recommendations of two of our panels until the commission had completed its assessment project – a minimum of 16 months from whenever they start.

I thought that would be unacceptable to you and, therefore, the Commission refused to speak at the opening plenary session. I thought the proposed delay – 16 months – was particularly inappropriate in view of the fact that the National Beer Wholesalers Association and the National Association of Broadcasters, with participating legal counsel, in the most intense discussions Wednesday, Thursday, and today, requested only a 45-day comment period followed by a 30-day delay before final publication.

As for me, I intend to ignore those who would lynch or execute a first offender in drunk driving, just as I would ignore those who say that it has not yet been proven that alcohol is responsible for impaired driving. I intend to assume what leadership role I may between these two extremes and, as I have with other issues, transmit what energy, enthusiasm, and credibility I have to this war against impaired driving.

I will think of lots more and keep you posted.

Thanks to Amy Barkin, Steve Moore, and many others who have brought us this far with the workshop and thank you, Susan Lockhart, for all you will do with me as we face this problem in the new year.

And thank all of you for coming. Have a blessed holiday season and all that's good in the new year.